NOW “Lead” this: SAFE CARE
Creating a Culture of Safety

Introduction

Confronted with a hospital that routinely recorded a patient fall daily and staff perceptions that falls were routine, abysmal hand hygiene, narcotic diversions, and skyrocketing CLBSIs coupled with alarming NDNQI results, the CNO stopped the line.

The CNO and nursing leaders with frontline nurses implemented a comprehensive SAFE CARE culture, transforming care across 18 units in 8 weeks to create the synergy that resulted in sweeping changes at the frontline.

Implementation

Safety First: Focus Leadership AND Frontline on Patient Safety

Awareness: Achieving with data best practice outcomes for every patient

Focus: Real Time “performance improvement”

Expectations: Exceptional CARE for every patient

Communication: Clear leadership expectations for JUST CULTURE

Accountability: Action to Active SAFE CARE

Recognition: Recognize/Share Innovations…..Success across all Units

Excellence: Empowering Frontline to TRANSFORM CARE

Equipment & Resources

• Right Supplies at the right time
• Safe patient handling program
• Smart coaches

Patient/Family Engagement

• Care Boards
• Hourly rounding
• Patient Advisory councils
• Care Partners

Performance Improvement

• Real Time PI
• Debriefings
• Peer Reviews
• Root Cause Analysis

Education

• Simulation
• Just Culture
• Online modules
• Team STEPPS

Communication

• Debriefings after incidents
• Safety Huddles
• Cx of Safety Unit Boards
• Leadership 24/7/365 alerts for incidents
• Safety Alarms
• Let’s Talk: Staff Rounds

Leadership Engagement

• Just Culture
• Unsafe Acts algorithm
• Cx of Safety Steering Team
• Leadership reviews of incidents weekly

Awareness, Learning, adaptability…leading by example

Vigilance, Discipline, Integrity: Zero defects in an obtainable goal

Recognition of Opportunities

• Scorecards
• NDNQI benchmark for quality outcomes
• NDNQI benchmark for staff satisfaction and engagement
• AHRQ Survey for safety
• Event reporting systems

Sustain the Gain

• Debriefings
• Just Culture
• Unsafe Acts algorithm
• Cx of Safety Steering Team
• Leadership reviews of incidents weekly

Awareness, Learning, adaptability…safety lives in conversation

Vigilance, Discipline, Integrity: Zero defects in an obtainable goal

Discussion

SAFE CARE is not about tasks

Accountably to create SAFE CARE increases with the pressure of Transparency

Sharing days “since last fall” openly brings PRIDE

Changing a culture takes focus, endurance, empowerment, and leadership support

It takes PASSION even when you have nothing left to give…

Patients and families provide insight

Results

• 50% reduction falls and falls with injuries
• 50% improvement in units achieving NDNQI mean
• 45% improvement hand hygiene
• Reduced CLBSI rate by 36%
• Reduced staff narcotic diversions
• NDNQI RN satisfaction 10/10 domains improved with 100% above mean
• Reduced restraint utilization by 30% with 50% improvement perfect documentation

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